Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: TRIUMPH HOSPITAL OF EAST HOUSTON C/O HOLLOWAY & GUMBERT 3701 KIRBY DR STE 1288 HOUSTON TX 77098-3926	MFDR Tracking #:	M4-03-7714-01
Respondent Name and Box #: Continental Casualty Co. Box #: 47		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Fees for goods and services provided by Triumph Hospital of East Houston are based upon the rates that the market will bear in the geographic locale of the hospital."… "the prices which the hospital must charge for its goods and services are affected by market forces beyond its control, including but not limited to the costs for raw materials, labor and transportation of goods and supplies."… "Our client's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area."… "it is the position of Triumph Hospital of East Houston that all charges relating to the admission"… "are due and payable as provided for under Texas law."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $983.88
3. Hospital Bill
4. EOBs
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: ""Provider has submitted no evidence to show that the amount it seeks is fair and reasonable reimbursement."… "Carrier has reimbursed Provider a fair and reasonable amount, in accordance with the statutory standards for reimbursement set forth in section 413.011 of the Act. Carrier's rate of reimbursement is validated by: 1) the Commission's *per diem* rates for procedures performed on an inpatient basis; 2) the Medicare payment rates for ambulatory surgical procedures; 3) the payment rates established by the workers' compensation authorities in Nevada, Massachusetts, Pennsylvania, and Mississippi; and 4) recent decisions of the State Office of Administrative Hearings."…

"Given that TWCC has determined that $1,118 is appropriate reimbursement of facility charges for a surgical procedure performed in an acute care hospital with a length of stay in excess of 23 hours, $870 is certainly appropriate reimbursement of facility charges for a lumbar ESI performed in an outpatient setting with a length of stay substantially less than 23 hours."… "In light of the reduced expenses incurred in an outpatient setting, it is simply not reasonable to pay *more* in facility charges when a procedure is performed on an outpatient basis rather than an inpatient basis."…

"Because the Medicare population is at least of an equivalent standard of living to workers' compensation patients, the Medicare rates are relevant to determine appropriate reimbursement under the statutory criteria for payment set forth in the Act, as stated by the Commission. The fact that reimbursement of $870 is more than twice the amount that would be allowed under Medicare's current rules for ambulatory surgical services overwhelmingly establishes that this rate of reimbursement is more than appropriate under the criteria for payment set forth by the Act."…

"Provider has not met its burden of proof to establish that its charges comply with the Act's statutory standards for reimbursement and that Carrier's rate of payment of does not. Therefore, Provider is not entitled to additional reimbursement."

Principle Documentation:

1. Response Package
2. EOBs
3. Medicare Payment Policy Documentation
4. Fee Schedules for Nevada, Massachusetts, Pennsylvania, and Mississippi
5. Supporting SOAH Decisions

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
8/14/2002	M	Outpatient Surgery	$983.88	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - M – "No Mar"

   With additional payment advice codes:
   - 1 – "No MAR."
   - 2 – "The charge exceeds usual and customary."
2. This dispute relates to an outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division Rule at 28 TAC §134.1, 27 TexReg 4047 (May 10, 2002) which requires that "reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011"…
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division Rule at 28 TAC §133.307(g)(3)(D), effective January 2, 2002, 26 TexReg 10934; amended to be effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines)". This request for medical fee dispute resolution was received by the Division on June 9, 2003. The requestor's position statement asserts that "it is the position of Triumph Hospital of East Houston that all charges relating to the admission"… "are due and payable as provided for under Texas law." In support of this the requestor states that "Fees for goods and services provided by Triumph Hospital of East Houston are based upon the rates that the market will bear in the geographic locale of the hospital."; however, the requestor did not submit evidence to support the methodology it used to determine the rates it charged for the disputed services or to support what the market would bear for the disputed services in the provider's geographic locale. The requestor additionally asserts that "Our client's rates for the goods and services it provides are similar to and competitive with other general hospitals in the greater Houston, Texas area."; however, the requestor did not submit documentation to support that the provider's rates are similar to or competitive with other hospitals in the area. The requestor further asserts that "the prices which the hospital must charge for its goods and services are affected by market forces beyond its control, including but not limited to the costs for raw materials, labor and transportation of goods and supplies."… "Fees are set based upon the cost factors above, as well as the cost of maintaining the physical plant of the hospital, including but not limited to highly trained nursing and administrative personnel."; however, the requestor did not submit evidence to support its costs for raw materials, labor, transportation of goods and supplies, maintaining the physical plant of the hospital or nursing and administrative personnel.
5. Moreover, a reimbursement methodology based on hospital costs does not, in itself, produce a fair and reasonable reimbursement amount. This methodology was considered and rejected by the Division in another fee guideline adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that:

   "The Commission [now the Division] chose not to adopt a cost-based reimbursement methodology. The cost calculation on which cost-based models"… "are derived typically use hospital charges as a basis. Each hospital determines its own charges. In addition, a hospital's charges cannot be verified as a valid indicator of its costs."…

"Therefore, under a so-called cost-based system a hospital can independently affect its reimbursement without its costs being verified. The cost-based methodology is therefore questionable and difficult to utilize considering the statutory objective of achieving effective medical cost control and the standard not to pay more than for similar treatment to an injured individual of an equivalent standard of living contained in Texas Labor Code §413.011. There is little incentive in this type of cost-based methodology for hospitals to contain medical costs."…

Additionally, the Division found that a reimbursement methodology based upon payment of the hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the same fee guideline adoption preamble as above which states at 22 *Texas Register* 6276 (July 4, 1997) that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

6. Further review of the documentation submitted by the requestor finds that the requestor has not addressed how payment of the amount sought would meet the requirements of 28 TAC §134.1 and Texas Labor Code §413.011(d). The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional reimbursement cannot be recommended.
7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.